A. OTHER THIRD PARTY LIABILITY (TPL) COVERAGE

The Wisconsin Medical Assistance Program (WMAP) is the payer of last resort for any service covered by the WMAP. If the recipient is covered under third party insurance, the WMAP reimburses that portion of the allowable cost remaining after all other third party sources have been exhausted. Refer to Section IX-D of Part A of the WMAP Provider Handbook for more detailed information on services requiring third party billing, exceptions, and the "Other Insurance Discrepancy Report."

B. MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT

Recipients covered under both Medicare and Medical Assistance are referred to as dual-entitlees. Claims for Medicare covered services provided to dual-entitlees must be billed to Medicare prior to billing the WMAP. However, Community Support Programs (CSPs) are not a Medicare-covered service, and thus billing Medicare for dual entitlees is not required. A Medicare disclaimer code must be indicated on the claim if the recipient's Medical Assistance identification card indicates Medicare coverage. Refer to Appendix 1 of this handbook for detailed claim form instructions.

C. BILLED AMOUNTS

Providers must bill the WMAP their usual and customary charges for the actual number of hours of services provided, that charge being the amount charged by the provider for the same service when provided to private pay patients. Providers who do not have a usual and customary charge must bill the WMAP the estimated cost for services provided.

For providers using a sliding fee scale for specific services, usual and customary means the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Providers may not discriminate against Medical Assistance recipients by charging a higher fee for the service than is charged to a private pay patient.

Providers should refer to Appendix 1 of this handbook for complete billing instructions.

D. BILLING INCREMENTS

The CSP should bill in hourly units. CSPs may bill in one-tenth hour increments or round to the nearest half hour.

When a CSP is rounding to the nearest half hour and provides more than one service to a Medical Assistance recipient during a single encounter, the provider may bill for the total time, coding each 1/2 hour increment according to the service provided. If the time spent on various services provided are in less than 1/2 hour increments, the provider should bill the entire time to the service which is predominant.

Example: If a CSP professional spends one hour with a client, 1/2 hour of which is psychosocial rehabilitation and 1/2 hour of which is symptom management, the provider should bill as follows:

.5 Psychosocial rehabilitation (procedure code W8273)
.5 Symptom management (procedure code W8243)

Example: If a CSP professional spends 1/2 hour with a client, of which 10 minutes is employment related skill training, 15 minutes is psychosocial rehabilitation, and 5 minutes is symptom management, the provider should bill as follows:

.5 Psychosocial rehabilitation (procedure code W8273)

If a provider bills in one-tenth hour increments, each procedure should be billed separately.

E. CLOZAPINE MANAGEMENT

Providers must bill a quantity of "1" in element 24G of the HCFA 1500 claim form for each week of Clozapine Management services, regardless of the actual number of services provided. All claims for Clozapine Management must have the prior authorization number indicated in element 23 of the HCFA 1500 claim form. The date of service indicated in element 24a must be the last day of the calendar week on which service was actually provided.

F. CLAIM SUBMISSION

Paper Claim Submission

CSP and Clozapine Management services must be submitted using the National HCFA 1500 claim form. Sample claim forms and completion instructions can be found in Appendices 1 and 2 of this handbook.

CSP and Clozapine Management services submitted on any other form than the National HCFA 1500 claim form are denied.

The National HCFA 1500 claim form is not provided by the WMAP or EDS. It may be obtained from a number of forms suppliers. One such source is:

State Medical Society Services
Post Office Box 1109
Madison, WI 53701
(608) 257-6781 (Madison area)
1-800-362-9080 (toll-free)

Completed claims submitted for payment must be mailed to the following address:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Paperless Claim Submission

As an alternative to submission of paper claims, EDS is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as claims submitted on paper and are subjected to the same processing requirements as paper claims. Providers submitting electronically can reduce their claim submission errors. Free software and consultation services are provided. Additional information on alternative claim submission is available by contacting:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

Submission of Claims

All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date the service was rendered. Claims for coinsurance and deductible for services rendered to recipients covered by both Medicare and Medical Assistance must be received by EDS within 365 days from the date of service, *or* within 90 days from the Medicare EOMB date, whichever is later. (Refer to Section IX of Part A of the WMAP Provider Handbook for exceptions to the 90-day extension.) This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

G. DIAGNOSIS CODES

All CSP claims must have a primary diagnosis of one of the ICD-9-CM (International Classification of Diseases, 9th Edition, Clinical Modifications) codes listed in Appendix 3 of this handbook. Claims received without an allowable ICD-9-CM code as the primary diagnosis are denied.

The complete ICD-9-CM code book can be ordered from:

ICD-9-CM
Post Office Box 991
Ann Arbor, MI 48106

H. PROCEDURE CODES

HCFA Common Procedure Coding System (HCPCS) codes are required on all CSP claims. Claims or adjustments received without HCPCS codes are denied. Allowable HCPCS codes for CSP are included in Appendix 4 of this handbook.

I. FOLLOW-UP TO CLAIM SUBMISSION

It is the responsibility of the provider to initiate follow-up procedures on claims submitted to EDS. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Providers are advised that EDS will take no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to EDS. Section X of Part A of the WMAP Provider Handbook includes detailed information regarding:

- the Remittance and Status Report
- adjustments to paid claims
- return of overpayments
- duplicate payments
- denied claims
- Good Faith claims filing procedures